Please Email Registration to: MPA.Info@tn.gov

REGISTRATION
MANDATORY PRE-SCREENING AGENT TRAINING
Please Print

Requested Training Date (see training announcement for dates) _____

Are you taking the initial training to satisfy MPA recertification requirements? Yes □ No □

Name (as listed on your license): _____

Agency (if applicable): _____

Business Address: _____

Business Phone: (_____)_____

Business E-mail: _____

Home Address: _____

Home Phone: (_____)_____

Home E-mail: _____

Why are you interested in becoming designated as a MPA?

_____

Are you employed full---Time or part---time by a TDMHSAS contracted crisis provider? Yes □ No □

I am a (check all that apply):

❒	Licensed physician with training, education, or experience in psychiatry	Expiration date: _____
❒	Licensed psychologist designated as a health service provider	Expiration date: _____
❒	Licensed psychological examiner	Expiration date: _____
❒	Licensed senior psychological examiner	Expiration date: _____
❒	Licensed master social worker (LMSW) with two years of mental health experience* (sign statement below)	Expiration date: _____
❒	Licensed clinical social worker	Expiration date: _____
❒	Licensed or certified marital and family therapist	Expiration date: _____
❒	Licensed nurse with a masters degree in nursing who functions as a psychiatric nurse	Expiration date: _____
❒	Licensed professional counselor	Expiration date: _____
❒	Licensed Physician's Asst. with a master's degree & expertise in psychiatry as determined by training, education or experience	Expiration date: _____

*** As a licensed master social worker, I affirm that I have two (2) years of mental health experience.** _____ **LMSW Signature**

Signature:_____ **Date:** _____

Revised June 2018